AIDS Workshop

REPORT

Chennai, India,
13-17 November 1998

THE LUTHERAN WORLD FEDERATION
LUTHERISCHER WELTBUND - FEDERACIÓN LUTERANA MUNDIAL - FÉDÉRATION LUTHÉRIENNE MONDIALE

This report contains papers and reports of the AIDS Workshop in Chennai, India. This publication was prepared by the LWF/DMD Desk for Youth in Church and Society.

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AWARENESS-RAISING PROGRAM ON HIV/AIDS

HIV/AIDS YOUTH WORKSHOP

in Chennai, India, 13-17 November 1998

REPORT

Lutheran World Federation
Department for Mission and Development
Desk for Youth in Church and Society

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INTRODUCTION

Dear friends,

The report you have in your hands is the product of the workshop organized by the LWF Youth Desk in Chennai, India (November 13-17, 1998) for young people from LWF member churches in Asia. We had a blessed time of learning and sharing and mutual exchange on the very painful issue of HIV/AIDS. This report seeks to capture some of the thoughts presented at the workshop. We encourage you to use it as a resource in activities which we very much hope you are undertaking in your own churches and youth groups. We also hope that churches which were not able to send representatives to the workshop will find this report both encouraging and helpful in dealing with HIV/AIDS.

The young people present at the workshop have demonstrated a great potential to work for and achieve change in their communities. The words of the apostle Paul from 1 Corinthians 1:5-9 were celebrated and became alive in our meeting and are quoted here again to provide motivation and strength:

> "...for in every way you have been enriched in [Christ], in speech and knowledge of every kind — just as the testimony of Christ has been strengthened among you — so that you are not lacking in any spiritual gift as you wait for the revealing of our Lord Jesus Christ. He will also strengthen you to the end, so that you may be blameless on the day of our Lord Jesus Christ. God is faithful; by him you were called into the fellowship of his Son, Jesus Christ our Lord."

Ondrej Prostrednik
Secretary for Youth in Church and Society

From Assembly Report, p. 67
The Role of the Church in the Care of People Living with HIV/AIDS

Recognizing the HIV/AIDS pandemic has intensified and continues to spread throughout the world, especially in the economically poor countries;
Recognizing that the people most affected by the HIV virus are the poorest of the poor, children, young and productive persons, women, the illiterate and the marginalized;
Recognizing that the HIV/AIDS problem should not only be approached from the medical point of view but also from the concern for human dignity and the right of the individual to enjoy the highest possible quality of life;
Convinced that HIV/AIDS is a disease like any other disease which should not be confused with moral diagnosis;
Recognizing that people living with HIV/AIDS are often neglected, rejected and ostracized by relatives, friends and society; and
Recognizing the churches' understanding of inclusiveness;
Be it resolved that the Assembly:

- reaffirms all resolutions declared by the Lutheran World Federation on pastoral care, advocacy and alleviation of suffering for people living with HIV/AIDS; and
- urges the member churches to press towards the implementation of this and previously declared resolutions on HIV/AIDS into action.

Opening of the LWF Youth Workshop on HIV/AIDS

Chennai, India, November 13-17, 1998

Ondrej Prostrednik

Dear friends,
I would like to welcome you at this workshop on behalf of the LWF Youth Desk. I am glad that after all preparations we are finally here and can start our work. In my opening remarks I would like to focus on the following points:

1. What is the LWF?

The LWF is a global communion of Lutheran churches with a history of 50 years of active involvement in ecumenical relations, theology, humanitarian assistance, human rights, communication and various aspects of mission and development work. The LWF now has 124 member churches in 69 countries representing over 57 million of the world's 61 million Lutherans.

Very often we get letters at the Youth Desk in which young people ask: How can I become a member of the LWF?, because they think that what the LWF is doing is interesting and important. Our response to this type of question is usually very easy and short: If you are a member of one of our 124 member churches you are member of the LWF. But we know that there is more behind this question than an interest in the mere organizational structure of the LWF. The real question is: What is the meaning of being a member of the LWF? What is the benefit of being a member of the LWF?

In recent years, the LWF has been working quite intensively with the term "communion building". We have become aware that the level of information and the level of awareness about the existence of a worldwide Lutheran communion, which has its organizational expression in the LWF, is very low among the members of most of the Lutheran churches. As a result of that, many Lutherans live isolated in their national churches, very often left with the feeling of being a very tiny minority in an ocean of other confessions or religions, as is mostly the case here in Asia.

In an era of globalization, with all its positive and negative effects, this has to be changed. This is a challenge especially for the young generation. With increasing communication facilities, the growth of a global culture, in a time where most of the problems become very similar in all parts of the world - and HIV/AIDS is a very good example of this - we have to learn how to strengthen our communion and benefit from the diverse gifts which Lutherans have in different parts of the world.

The LWF is trying to do this through a number of activities. The Youth Program of the LWF is one of those activities trying to strengthen the ministry of our member churches to young people or with the young people. Building regional Lutheran youth networks is one of the methods how to facilitate exchange of resources and experiences on the global level.

2. Why this workshop?
Is HIV/AIDS a business of the church? Shouldn't we leave this work to the health care systems in our respective states? Aren't there enough NGOs dealing with this problem? Aren't the people affected by HIV/AIDS those living outside the church? Should the churches not rather focus on mission efforts? And why doing this workshop for young people? Is it not inappropriate to talk with the young people in the church about sexually transmitted diseases? Would all these problems not be solved if we only do our preaching and teaching more faithfully?

These are all questions which you were probably asked as you decided to attend this workshop, or you have asked them yourselves. Unfortunately, the reality is that HIV/AIDS goes across all religious, confessional, social and whatever boundaries. The statistics show, that it is exactly the sectors of our societies which have the less information about HIV/AIDS, who are the most affected. The church is definitely called to serve its people with the right information in order to help them to be protected from the spread of the HIV/AIDS. So it is not only the pastoral care for those already infected, to which we are called as church, but it is also the prevention, which we are called to do among the people in our communities, if we claim to be faithful to our calling as Christians.

One of the worst affected countries in the world by HIV/AIDS is the African country of Uganda. In a recent presentation on positive results in the fight against the spread of HIV/AIDS, the UNAIDS agency used the case of Uganda as an positive example in fighting the spread of HIV infection. The number of HIV infections has fallen dramatically in the recent two years. What is the secret? A strong involvement of religious NGOs in the community based prevention programs against HIV/AIDS and energetic government decisions in this regard.

The LWF Ninth Assembly in Hong Kong reaffirmed all resolutions declared by the LWF on pastoral care, advocacy and alleviation of suffering for people living with HIV/AIDS and urged the member churches to press towards the implementation of these and previously declared resolutions on HIV/AIDS into action (Assembly Report, p. 67). The LWF/DMD Youth Desk has for several years been involved in programs focusing on awareness-raising about HIV/AIDS, such as regional workshops, publication of resource materials and assistance to HIV/AIDS related activities in member churches targeting youth. After two regional workshops for youth in Africa (1993 and 1996) it was now time to organize a workshop in Asia, a region which after Africa has the next highest number of people living with HIV/AIDS (6.5 million).

3. What are the aims of the workshop?
We have informed you in our mailings about the aims of the workshop. But let's just quickly refresh our minds.

We have called this workshop in order to:
a) identify different regional issues and problems connected with the HIV/AIDS epidemic and the obstacles to and possibilities for church youth work to deal with these issues;
b) to work specifically with the ethical aspects, and what the churches' contribution to the fight against the spread of HIV/AIDS is;
c) to identify concrete ways in which the youth in the churches might take action in church and society to show solidarity with people affected by HIV/AIDS.

4. How are we going to achieve these aims?
We have a number of experts at our disposal who will be our facilitators in sessions dealing with different aspects of HIV/AIDS. But it is not only the resource persons who will contribute to the program. We very much hope and encourage you to actively participate in the respective sessions. Because you are also experts in your own context. And we have gathered you here in order to draw on this expertise.

5. Words of thanks
Let me conclude this introduction to our program with a few words of thanks:

To the UELCI for accepting to host this workshop. We feel very honored that Dr. Rajaratnam, President of the National Council of Churches in India, is among us today to officially open the workshop. Please give our greetings and our thanks also to Dr. Prasanna Kumari, Executive Secretary of the UELCI.

We are thankful especially to our local coordinator, Dr. Sheila Shyamprasad. It was a pleasure to work together with you in preparing this workshop. Without your involvement, we would never be able to put up such an interesting program with such highly qualified resource persons.

Thanks also to all our resource persons for accepting our invitation. We are all looking forward to learn from you.

Thanks also to Rev. Thomas Kurien, the manager of the CRENIEO Center for opening its beautiful facilities for our workshop.

Finally, thanks to all of you, dear participants, for taking the time and courage to undertake the long road and come to this workshop. We ask our Lord, that He might bless our efforts and turn this meeting into a fruitful learning experience with deep spiritual basis.

Thanks for your attention.

UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AID

AIDS epidemic update:

December 1998

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UNAIDS
UNICEF · UNDP · UNFPA
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World Health Organization

Global summary of the HIV/AIDS epidemic, December 1998

People newly infected with HIV in 1998	**Total**	**5.8 million**
	Adults	5.2 million
	Women	*2.1 million*
	Children <15 years	590 000
No. of people living with HIV/AIDS	**Total**	**33.4 million**
	Adults	32.2 million
	Women	*13.8 million*
	Children <15 years	1.2 million
AIDS deaths in 1998	**Total**	**2.5 million**
	Adults	2.0 million
	Women	*900 000*
	Children <15 years	510 000
Total no. of AIDS deaths since the beginning of the epidemic	**Total**	**13.9 million**
	Adults	10.7 million
	Women	*4.7 million*
	Children <15 years	3.2 million

Increasingly, the spotlight is on the spread of HIV through the **Asian continent,** especially in South Asia and East Asia. While rates remain low relative to some other regions, well over 7 million Asians are already infected and HIV is clearly beginning to spread in earnest through the vast populations of India and China.

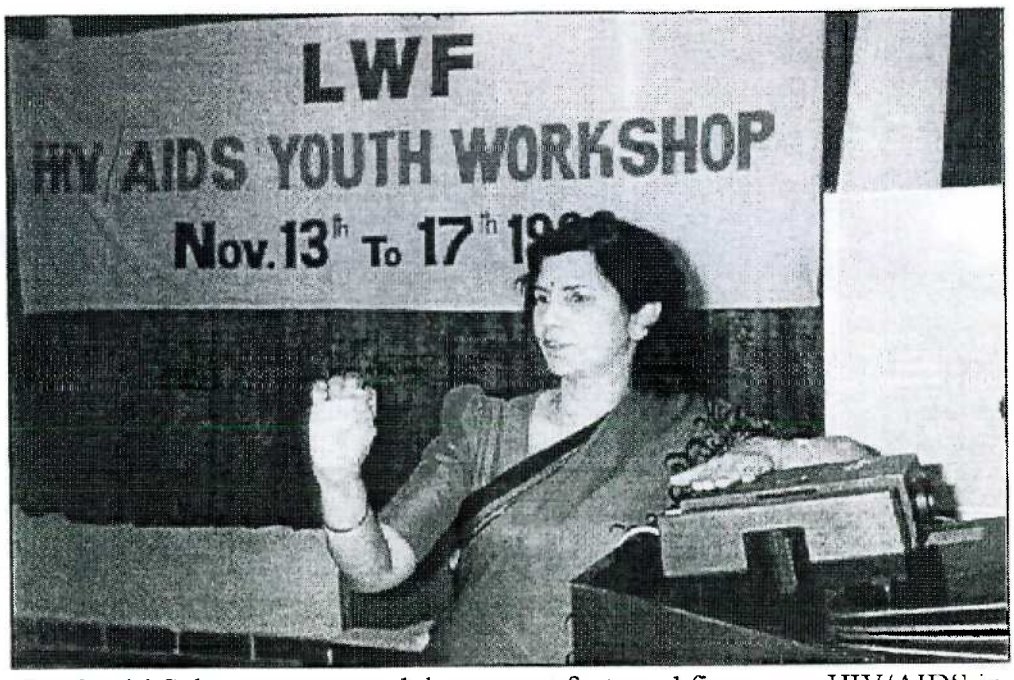
India provides an interesting example of the shifting patterns of HIV.

- Until recently, it was commonly assumed that HIV infection in the world's second most populous nation was concentrated in urban sex workers and their clients and in drug injectors living in a few states. The last round of sentinel surveillance in antenatal clinics shows that in at least in five states, more than 1% of pregnant women in urban areas are now infected.
- India's rural areas—home to 73% of the country's 930 million people—were thought to be relatively spared by the epidemic. Again, new studies show that at least in some areas, HIV has become worryingly common in villages as well as cities. A recent survey of randomly selected households in Tamil Nadu found that 2.1% of the adult population living in the countryside had HIV, as compared with 0.7% of the urban population. For this small state, with its population of 25 million, the study findings suggest that there are close to half a million people already infected with HIV in Tamil Nadu. Considering that nearly 10% of the people surveyed had gonorrhoea, syphilis or another sexually transmitted disease, HIV clearly has fertile ground for further spread.

Regional HIV/AIDS statistics and features, December 1998

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate[2]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[3] for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	late '80s	210 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	late '80s	560 000	200 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.4 million	160 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	330 000	45 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	270 000	80 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	500 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	890 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	600	0.1%	5%	MSM, IDU
TOTAL		**33.4 million**	**5.8 million**	**1.1%**	**43%**	

- The virus is firmly embedded in the general population, among women whose only risk behaviour is having sex with their own husbands. In a study of nearly 400 women attending STD clinics in Pune, 93% were married and 91% had never had sex with anyone but their husband. All of these women were infected with a sexually transmitted disease, and a shocking 13.6% of them tested positive for HIV.



Dr. Suniti Salomon presented the current facts and figures on HIV/AIDS in India. In 1986 Dr. Solomon and her team documented the first evidence of HIV infection in India.

CULTURE, CHRISTIANITY AND AIDS

Dr. Sheila Shyamprasad, Co-ordinator AIDS Desk, United Evangelical Lutheran Church in India (UELCI)

Dr. Sheila Shyamprasad
local coordinator of the workshop

Culture can be defined as the habits, expectations, behavior, rituals, values and beliefs that human groups develop over time. It determines people's feelings and beliefs about health and illness, about caring for the infirm and about death and loss. Cultural attitudes towards sexuality can influence the spread or containment of HIV infection.

Culture, again is not a constant. Beliefs and attitudes change from time to time and what prevails in a certain period may not find relevance in another era or century. Attitudes and values of traditional and olden cultures are different from the present modern day culture and with context to HIV/AIDS at times, it seems that had the virus made its appearance in an earlier era, the scenario may have been different.

TRADITIONAL CULTURE

Survival of the Community

Traditional culture placed great emphasis on the survival of the group. The stability of the community and its continuity was of prime importance. Traditions and social structures in India have remained intact in spite of hundreds of years of foreign domination. These traditions and values have helped the community to overcome and tide over any crisis or problem which threatened the existence of the group.

Women

Great emphasis was placed on the chastity of women. Even today, in Indian culture, there are still many social restrictions that are imposed upon women. It was also emphasized that child-bearing is the priority as far as women are concerned and sexual gratification of the fairer sex was not even mentioned. This may appear unfair to people in the western world, but it must be remembered that these restrictions and attitudes were to ensure the propagation of the family, the kin and the race. It was felt that unregulated freedom of individuals, especially women, would upset this and the stability of the group would be threatened.

Marriage and Sexuality

The traditional attitude to marriage is also different from that which is prevalent today. Marriage was viewed as a union of two people -- of their bodies and souls -- a union which was considered to be final. Marriage vows were meant to be fulfilled. Priority was given to fulfil obligations in life as a family unit and then to procreate and last of all to sexual enjoyment. Almost all olden cultures, be it eastern or western, placed emphasis on procreation in marriage. Sexuality was not discussed as an isolated entity but in a more wholesome context. The present day attitude views sexuality as isolate -- not in relation to life but as an entity where the main essence is simply derivation of individual sensual pleasure.

Family

The family system in traditional cultures is hierarchial in nature. Parents are entitled to total obedience and loyalty from their children. The husband's authority is supreme and the traditional Indian women take a lot of pride in fulfilling the needs of the husband and the family. In return, the image of the mother is idealized -- this is because of her great capacity for devotion and self-sacrifice. The mother is the chief care-giver in the family. Those who are at the receiving end of her care, also reciprocate by giving back that care. It is very natural that in old age the parents are taken care of by the children to give back what they have received. The Biblical commandment of honoring one's parents is well understood by Indian society. The joint-family system in India has done much to uphold the system of caring. As institutional care is not prevalent in India and is also expensive, family members have to care for one another. Even these days, where the joint-family system has been slowly eroded and replaced by the extended family, there is still a lot of solidarity and support in times of crisis.

Sexual Restriction

The power of sexuality is well recognized by all cultures. Indian culture emphasizes the importance of pursuing sex purposefully rather than becoming enslaved to it. Traditions and customs are such that an open expression of sexuality is sublimated -- duties and obligations to one's family and society supersede individual's pleasure. Social restrictions are placed to minimize temptation -- young people are forbidden dating, opportunities for young people to indulge in partying, drinking are made negligible. This ensures social control over the individual. Most Indian youth, however, accept such limitations in their stride and do not feel that they are being denied any privileges.

The Hierarchial System

Indian society is hierarchial as in t he Indian family. Male authority is considered supreme and women look upon the husband as divine. The duty of the wife is to be faithful to her husband irrespective of his scruples, morals, fidelity or attitude toward her. This gives rise to double standards. Men are given unlimited freedom over women, whereas, wives are expected to be devoted to their husbands whatever be the circumstance. Promiscuity, therefore, is very prevalent among men. It is the duty of the woman to procreate, whereas, it is the right of the man to enjoy sex. This has resulted in a booming sex industry. The outcome of this is the risk resulting from exposure of the housewife to the HIV virus and also the many women who are forced into prostitution. In the context of HIV/AIDS, one can see how the stage has been set for the transmission of the virus.

MODERN CULTURE

Rural Urban Disparity

With modernization, more jobs are to be found in cities and towns, people in villages have therefore moved into the urban areas to earn their livelihood. The cost of living in cities, however, is expensive and this results in men leaving their families behind in villages. There is bifurcation of the family. The man has to live away from his wife. He is tempted to squander the money he earns on drinks and other women. The HIV virus has walked into this changing scene. It is so easy for this single man to be come infected. He visits his village and his wife once in three months -- and thus the virus spreads. Some years ago this was not the prevailing scene. People stayed on in their villages and on their own farms. Families and systems kept together.

Changing Values

With the advent of satellite television channels and other modern methods of communication, people's values -- especially those of the youth -- have undergone a drastic change. Emphasis on purity and chastity is slowly being replaced by a more casual and liberal attitude to sex. Surveys among college students reveal theat 50% of boys and 25% of girls feel that pre-marital sex was O.K. A few years ago, such an attitude would have been considered scandalous. The HIV virus has been born into such a society.

Individualism

Indian society is now speeding towards ultra-modernization. Consumer capitalism, free market economy and liberal individualism are taking over. Young people are mostly concerned about their career prospects. A happy marriage is a priority only among 10-15% of young people. Young women now-a-days are not so keen to jump on to the matrimonial band-wagon. A well earning job and independence are more important. Marriage is considered to be a drudgery. It is more convenient to enjoy sexual pleasure outside the confines of a permanent, indissoluble institution like marriage. Emphasis on sex has gained precedence over fulfilling filial obligations -- thanks to the powerful influence of the media. One's individual pleasure and indulgence is now of primary importance. If partners find themselves sexually incompatible they split. The result is more partners and more spread of the virus.

Role of Elders

The hierarchial system of family is still prevalent in Indian society today. However, parents and elders are not given the same amount of obedience and loyalty as before. The role of elders is no longer as dominant as it used to be. One reason is with access to more information and modernization, children feel they know more than their parents. Secondly, in recent times the emphasis is more on self. Young people have more freedom to make their decisions and to run their own lives. It is also important for young people to be seen doing the "in" thing -- like drugs, sex. It is very easy to succumb to peer pressure. The virus has slowly crept into this scene.

Loss of Care

Women have now become career-oriented. Competition in the markets is stiff. If one has to move ahead and move fast, there is not enough time to care for those at home -- be it children or parents. One cannot afford it. So where is the question of caring for those with HIV/AIDS? Here

is a disease, where there is no cure -- only care. There is very little one can do for those affected with HIV/AIDS.

CHRISTIANITY AND AIDS

The two main issues that the church can involve in are Prevention and Care.

Prevention

Modernization brought with it a change of values especially pertaining to sexual attitudes; the virus, therefore, has taken a stronghold and is even now spreading its tentacles in all directions. On the other hand, recent figures indicate that the number of new infections from the western world is becoming fewer. The reason for this lies in the fact that people are aware and educated about the disease and modify their behavior. Modification of behavior, however, means that they practice "safer sex" -- in other words, condom protection. Is this all that the scientific world can offer, after so many years of research? If the church also takes the stand that this is the only way out, then we acknowledge and affirm that man has no control over his sexual impulses. It is no longer necessary that there should be a bonding of love between two sexual partners. Sex has become a mere function of the body like eating or breathing. The Bible s peaks of union between man and woman as 'one flesh'. It is difficult to perceive how sex with various partners can go along with the concept of 'one flesh'. Casual sex which means pre-marital and extra-marital sex conflicts with this view. The secular world bows down to the fact that the condom is the only fortification against the virus. People now talk of 'having sex' rather than making love. The Bible, however, reflects the view that humans should practice 'responsible sex' or 'safe sex' -- this is sex between two partners united in love and mutually faithful to one another. True, the condom has a definite role to play in HIV prevention and one should not decry the efforts of those who promote it but the church should advocate its emphasis on safe sex rather than rely on condoms. Sexual liberation erodes the foundation of the family life. It is not only the individuals who suffer but also the families of these sufferers are devastated. The bonding of love is very important if sex is to be 'safe'.

Caring

Caring is to meet another's needs. Care is compassion in action. The church and its members are meant to care. The emergence of HIV/AIDS has highlighted the importance of care. Jesus Christ healed the sick on a Sabbath; He risked breaking a commandment to bring about the healing. This is because He cared. Christ's second commandment to us is "Love your neighbor as yourself". In the present day world, 'individualism' reigns supreme. It is each man or woman to himself/herself. There is no place for the neighbor. There is only self. We seem to have lost sight of our neighbors. Our life is such that it can take in only two things -- work and pleasure. There is no room for neighbors. This is not only in conflict with the second commandment of our Lord, but also to the words in John 3:16, where God loves us to the point that He gave Himself for us. Jesus also mentions in Matthew 25:40, that whatever is done to the least of humans, the same is rendered unto God. The rich man was indifferent to the needs of Lazarus at his gate; he lost his place in heaven. The Good Samaritan, however, is exemplified by Jesus for his ability to care. The Bible could not have been clearer in its mandate to us regarding care.

At times, people condescend to offer care to the 'least of their brethren' -- their brethren who have acquired this disease by 'sinning'. Judgementalism should have no part in this. Christ did not condemn the woman who was brought before Him caught in adultery. He challenged those around to cast the first stone and although He could have very well cast it Himself, He refrained from doing so. He pardoned the woman but at the same time He did not condone her -- He told her not to sin any more. He truly cared for her. The life of Jesus gives us so many examples of how He went out of the way to befriend the marginalized. He sought Matthew, Zacchaeus, Mary Magdalene! Who else but Jesus would have given them a chance?

The Christian role, therefore, has been clarified. We are called to care and to care without reservations, without judgement. In modern culture with erosion of family values, the epidemic can explode and advocating safe sex is a prophetic role given to the church which could go a long way in containment of the virus.

EXPOSURE PROGRAM

The exposure program on Sunday 15 November was a special experience. It started with a service early in the morning. Later during the day, participants visited two very interesting places. One of them was CHES, Community Health Education Society, a clinic with a special program for HIV positive children. Dr. P. Manorama (above with her children), who runs this as a normal private clinic, started to adopt HIV positive children and also offers beds for AIDS patients. She has a small team of very dedicated co-workers who mostly do home based care. It was a very moving experience to meet these children, of whom there are about ten. One felt the family spirit and love in this place.

BROKENNESS TO WHOLENESS

HIV/AIDS PREVENTION CURRICULUM

Robert Lane, Lutheran AIDS Network, USA

INTRODUCTION

Brokenness to Wholeness: An HIV/AIDS Prevention Curriculum is designed for young people ages 15-18. It is based on the need for young people to explore what the realities of HIV mean for their lives in general and in light of their faith and faith community. Participants in the sessions hear about and are affected by the disease through information gained at school and through the media, friends and/or family members who are infected with HIV, and possibly their own risk behaviors. The goals for the curriculum are as follows:

1. To help participants explore how risk behaviors relate to the brokenness we find in our communities, our relationships, and in ourselves.

2. To help participants understand the facts ab out transmission and prevention of HIV/AIDS and how it affects adolescent and young adult populations.

3. To help participants explore the differences between life-enhancing and risk-producing behaviors and the values that influence their decisions to choose between them.

4. To help participants plan ways to respond, both individually and as a community of faith, to others who are infected with HIV.

The course is divided into four sessions. The contents of each session are as follows:

SESSION 1: SEARCHING THROUGH BROKENNESS

- explores the meaning of brokenness and risk behaviors
- explores our relationship with Jesus, alongside the reality of sin and brokenness in our communities
- discusses God's response to sin through us and in Holy Communion
- encourages participants to consider how to work together to rebuild community

SESSION 2: ABOUT HIV/AIDS -- THE BASICS

- distinguishes between myths and facts about HIV transmission
- provides the means for young people to explore the facts of the disease and how it affects lives
- helps participants understand ways to prevent the disease

SESSION 3: MAKING LIFE-ENHANCING DECISIONS

- reminds participants of the connection between their position as children of God through baptism and their self-worth
- helps participants understand the consequences of at-risk behaviors
- explores factors that contribute to self-confidence, self-esteem and establishing solid values
- encourages participants to imagine they have become HIV infected and consider how that might change the dreams they have for the future

SESSION 4: SOMEONE NEAR YOU HAS AIDS

- helps participants respond, both in attitude and action, to others who are infected with HIV
- encourages participants to plan ways to be involved in ministry with persons infected with HIV
- identifies from God's Word the gifts of wholeness God gives us to be a community of faith

The *Participant Book** is to be used independently by the participants for most of the course. The activities in the course will cause many of the young people to seriously think about themselves, their faith, and others. The *Participants Book* is designed to help them process what is done in the four sessions. They will need time to reflect and digest all of the material and activities. The questions in the beginning of the book are written to be used as a journal. Other sections of the book include HIV/AIDS information, resource lists, and a glossary.

LEADERSHIP

The leader of this course needs to be someone who is not a parent of one of the young people participating in the sessions. It would be very difficult for a young person to talk about his/her behaviors in a group with a parent as the facilitator.

The leader needs to be knowledgeable and comfortable with the topics of sexuality, drug use, death, and HIV/AIDS. It is also important that the leader has developed a relationship with the young people participating in the course that is based on mutual respect and caring.

Careful preparation of each session is very important. Seek assistance and information from others who specialize in the topic. Invite them to assist in part or all of the course, if appropriate. Don't feel that you must do everything by yourself.

Consider including a peer as a co-leader with the adult leader. The co-leader could be a college student or older youth who used to be a part of the youth group. You may want to consider a co-leader who is infected with HIV. The co-leader would also need to have a high comfort level with the topics of sexuality, drug use, and HIV/AIDS.

SETTINGS AND LEARNING STYLES

The curriculum includes enough material to design learning experiences to fit the time frame of your group. If time is limited, select activities to make as complete a session as possible. Consider expanding the four sessions to six or eight if additional time and interest are available. The topic of HIV/AIDS is a serious one and requires time for participants to reflect and ask questions. Make every effort to avoid leaving activities unfinished or rushed.

The curriculum can be used during Sunday morning or weekday education programs, youth group sessions, and retreat settings. Use during a weekly program allows participants to have time for reflection during the week before the next setting. A retreat setting allows for larger blocks of time and a concentrated focus for the topic. Each setting has its advantages.

Participants have different preferred styles of learning. The activities provide opportunities for discussion, visual learning, drama, and writing. The *Participant Book,* to be used independently by the participants, supports the sessions with reflection questions, information, and a glossary. The variety of types of learning activities are designed to help all the participants experience at least some activities suited to their style of learning.

COMMUNICATION WITH PARENTS AND THE CONGREGATION

The topic of HIV/AIDS, sexuality, and drug abuse often bring out feelings of fear and uneasiness among adults. It is important for parents and other adults in the congregation to be informed about what will be taught and why.

Consider using some or all of the following means to communicate the goals of the course:

- ✓ Schedule a meeting with parents before the course begins to explain its purpose and content.
- ✓ Schedule an abbreviated course for parents so they can more closely examine the course, gain awareness and appreciation for HIV/AIDS ministry opportunities, and discuss controversial portions of the curriculum (i.e., use of condoms, etc.).
- ✓ Adapt the "Sample Letter to Parents" (see box on page 24) and mail to each parent.
- ✓ Display the "Wall of Brokenness" from Session 1 during the course as a means of communicating to the congregation what the group is doing.
- ✓ Make copies of the "HIV/AIDS Fact Sheet" (see under appendices) from Session 2 for people in the congregation.

PREPARING TO LEAD THE SESSIONS

Work through each session before leading it. There are many different concepts, information, and activities to prepare. Specific information related to HIV:

Facts - HIV is transmitted by:

- sexual intercourse: vaginal, anal or oral; heterosexual or homosexual
- sores or breaks in the mucous membrane (lining of the mouth, vagina, and rectum) or skin that are exposed to infected blood, semen, or vaginal secretions
- shared razors, tattoo, or piercing equipment which might have blood on them
- shared syringes, needles and cookers
- transfusions of infected or other blood products
- HIV positive pregnant women to their children at birth (happens sometimes if through the birth process the baby comes in contact with infected bodily fluids)
- seropositive women nursing their children (this seems to be a somewhat limited means of transmission)

Myths - HIV is not transmitted by:

- touching, hugging, shaking hands
- social kissing, coughing, or sneezing
- teardrops, saliva, or sweat
- contacts with eating utensils, water fountains, toilets seats, telephones, typewriters, etc.
- using facilities such as public swimming pools, bathrooms, or gymnasiums
- being close to other people such as on a crowded bus, train or airplane, in a classroom, or restaurant
- sharing bed linens, towels, cups, straws, dishes, or other eating utensils
- mosquitoes or other bug bites

(*Participants Book,* Session 2, page 17)

HIV/AIDS can be a difficult topic for some to explore since it involves an honesty and directness about sexuality, drug use, and other sensitive subjects. Realize that these topics can also raise issues about sexual abuse. Good organization and preparation allows you as the leader to be calm, open to questions and necessary diversions on the topic, as well as to pace the sessions appropriately.

SETTING BOUNDARIES

Sensitivity and boundaries are needed when a group explores the topic of HIV/AIDS. Work with the group to set appropriate boundaries for the sessions. Some suggestions include:

- appropriate behavior as participants enter and leave the sessions;
- respect for the contributions of all members;
- development of a group contract to hold the stories of others in strict confidence;
- realization that the group is sharing in human life, something of high value.

Participants of the workshop enjoy the fellowship

THINGS TO REMEMBER

✓ Information and statistics about HIV/AIDS change frequently. New insights are gained as the medical world seeks to learn more about the virus and the best way to treat it. The information and statistics in this curriculum will quickly become outdated. For updated information contact:

UNAIDS (Joint United Nations Programme on HIV/AIDS)
20, avenue Appia, CH-1211 Geneva 27, Switzerland, http://www.unaids.org

CENTER FOR DISEASE CONTROL
National AIDS Clearinghouse: http://www.cdcnac.org
AIDS Clinical Trials Information Service: http://www.actis.org
HIV/AIDS Treatment Information Service: http://www.hivatis.org

LUTHERAN AIDS NETWORK, 1111 O'Farrell St., San Francisco, CA 94109, USA.

✓ A high trust level is needed among the group of young people before beginning the sessions. Wait several months to use the course if your group is newly formed or if you are a new leader. Use group building activities prior to the first session.

✓ Group dynamics will play an important role, especially in the first session. Avoid setting expectations for the first session too high. It may take the group a while to get comfortable with the topic.

✓ Many people (including young people) already know the basic facts about HIV transmission. What they have not done is connect those facts with their own lives and their faith. If your group is already informed about the facts, avoid belaboring them. Instead, explore what the facts mean.

✓ It is difficult for some people in the church to discuss sex and drugs. Expect to experience some denial. One example may be that it is only "other" young people who are sexually active and/or using drugs or alcohol. The denial continues when it is suggested that teaching safe sex and needle cleansing promotes sex and drug activities. This is not true. It is important to advocate among young people for sexual abstinence and healthy options to drugs and alcohol. It must be done in meaningful ways. At the same time the statistics are not telling the story of "other people's children." Many adolescents are sexually active and/or on drugs, including young people in our congregations. One important goal of the curriculum is infection control. Another goal is to work to develop healthy young people who feel good about who they are and fully capable of making healthy, life-giving choices.

✓ Someone in the group may have HIV infection, even if it is not revealed. Assume that to be true and avoid speaking about people who are HIV positive as "them", which helps avoid assigning blame or guilt.

✓ This course may trigger questions which will not be brought up in the group sessions. Be sure the door is open for individual follow-up, and be sure local resource phone numbers are made available.

✓ Some topics may trouble some of the participants. If this happens, invite them to speak with you or another person they trust.

✓ Point out that HIV disease is indiscriminate. Some groups may be over represented statistically, but our goal is not to blame or condemn. We are not out to make victims or add to the brokenness. Instead, we are to heal and make whole.

✓ Seek out music that is compatible with HIV/AIDS issues to use for background listening during activities and small group discussions and as young people arrive and leave after the sessions. ("His Name Was John" by Reba McIntyre is one example.)

BIBLICAL BACKGROUND

Building healthy communities and relationships amidst the reality of sin and evil in the world is a key concept in this curriculum.

God's Word tells us that, because of the power of Sin in the world, all our human communities are broken (or imperfect) to some degree. That is, since all human beings are imperfect, all human communities are imperfect as well. Sin, with a capital "S" is more than individual bad actions, or "sins". It is a power in the world that appears in the most unexpected places. It is a power that is too great for any of us to conquer alone. Read Ephesians 6:12.

One example of the power of Sin comes in Genesis 4 when, because of anger and jealousy, Cain killed his brother Abel. The murder of Abel was a sin (small"s"); but Cain was acting under the influence of Sin when he did this act.

Another example is found in Genesis 11 where a whole group of people came under the influence of Sin and all together set out to make themselves to be better than all other people. Read Genesis 11:1-9. Think of times when a whole community of people was overcome by Sin the world today. The cooperation during World War II in the killing of vast numbers of Jews is one example from recent history.

We do not need to be overcome by despair. Christ has conquered sin (i.e., "Sin") and evil. We participate in Christ's victory in our baptisms. As children of God, we are given the power to resist the sins that break community since Sin does not have total control over us.
(Romans 6:3-4 and Ephesians 4:7-8).

Having the appropriate attitude toward people with AIDS is another key issue we fact today. In John 9:1-3 Jesus teaches us that disease is not caused by someone's individual sins. Paul warns us against judgementalism in Romans 2:1-2. We are not to make assumptions that a person infected with HIV is any more or less sinful that someone who is not infected. Jeremiah 29:11-14 reminds us that God knows the plans set out for us. God is available to be with all of us.

SAMPLE LETTER TO PARENTS

Dear_____

Our youth group is planning to explore the issues of HIV/AIDS, using a new curriculum, *Brokenness to Wholeness: An HIV/AIDS Prevention Curriculum.* HIV/AIDS is an important issue for young people today. It is one of the leading cause of death among 15-24-year-olds.

Young people often know the basic information about the transmission of HIV. We feel it is important for them to have the opportunity to discuss what the disease and at-risk behaviors mean in their lives, especially as children of God and members of a faith community. Our attitudes and actions are a witness to the larger community. That is why they will also have the opportunity to discuss and even propose plans of action in being involved in ministry with people who are infected with HIV.

We invite you to attend a meeting on_____(date) designed to allow you to see the curriculum and ask questions about the course. This meeting is in advance of the time we will begin the course.

We look forward to talking with you at the meeting.

Yours in Christ,

* The *Participant Book* can be ordered from: Lutheran Services in America, attn. Lutheran AIDS Network, 2177 Young man Avenue, St. Paul, MN 55116-3142, USA

COUNTRY REPORTS :

INDIA (Ms. Bijaya Kondpan, Jeypore Evangelical Lutheran Church)

I bring greetings from the Jeypore Evangelical Lutheran Church (JELC) and especially from the Women's Desk and the JELC youth. This workshop is an incentive to us in the JELC.

This workshop is an incentive to us in JELC to take this problem of HIV/AIDS more seriously than before. The name HIV/AIDS is not unknown amongst us, but it is not taken as a life-threatening factor because the number of HIV/AIDS patients in Orissa is very low. The area of the JELC is a very underdeveloped area and the lack of proper medical investigations do not reveal the presence of HIV/AIDS patients. The few known cases are known only because of the close social setup. Cases of HIV/AIDS are also revealed due to the social stigma attached to this disease.

The area of the JELC does not facilitate a very rapid growth of this disease as it is in the larger populated areas or in cosmopolitan cities. A proper awareness is not present, though one cannot reject the fact of hidden presences of the disease. Hence it is a great opportunity for the JELC to mobilize its youth members of the church through:

1. Awareness Programs
2. Workshops
3. Bible Studies relating to the disease and the ethical dimensions of the faith.

These programs could help check the growth of HIV/AIDS among the young people. The JELC has taken initiative in this field and move to help also those who are outside the church.

Participants of the workshop learn how to rise HIV/AIDS awareness through drama

INDONESIA (Ms. Kathrin Eunice Simangunsong, The Indonesian Christian Church)

The number of HIV/AIDS cases in Indonesia is increasing rapidly. Up to the end of May 1998, 685 cases were reported. Experts estimate that the real number of HIV/AIDS cases in Indonesia is 200.000. From those 685 reported cases, the biggest number, that is 188 cases, are in Jakarta.

Indonesia is a big archipelago country located in South East Asia with a population of over two hundred million. Most of the society could not yet accept the presence of people with HIV/AIDS (PWA). There are still negative myths about PWA. This might be because AIDS is a relatively new illness and, therefore, the community has not yet clearly understood the way HIV spreads and how to behave normally in view of PWA. The family does not yet understand how to care for PWA at home. Thus, quite often PWAs are discriminated against and expelled from the family and community.

Considering this situation, Indonesia now has several organizations that engage in this problem. Yayasan Pelita Ilmu (Pelita Ilmu Foundation) located in Jakarta runs a program of community support for PWAs since 1994. This program is aimed at changing people's attitude from rejecting to accepting the presence of PWA. The activities of prevention and distribution of HIV/AIDS programs are:

1. AIDS awareness program in schools;
2. Training and information about HIV/AIDS;
3. Counseling clinic and anonymous blood tests;
4. HIV/AIDS Hotline Service answering all public questions about the disease.

In the University of North Sumatera, located in Medan, we have "Warung SaHIVa". This organization was founded in August 1998. The programs that have been carried out are:

- Training for volunteers who will help to take care of HIV/AIDS problems;
- Performed open discussion with students, informing them about HIV/AIDS;
- Distributed pamphlets that will raise awareness about HIV/AIDS.

But it is a pity that organizations like these only exist in the big cities. The smaller cities and villages do not have such organizations, although the number of infected people are rapidly increasing. We as Christian people have to feel concerned about this problem. Generally, churches in Indonesia are not yet directly involved in dealing with HIV/AIDS. This might be because churches still do not realize the scope of this problem. Therefore, they have no concept in the system of their organization and no funds allocated in their budget to prevent the spread of HIV/AIDS. What churches have done is restricted to preaching about how to live in accordance with God's words. This is no longer interesting for young people. They need something more attractive that will guide them to face all these problems in this era of technology. This is where it becomes challenging for the churches; how churches could take part in youth activities and how to have good conversations with young people. The reluctance of young people to come to the church will cause a decrease of faith and young people will rather turn to a life with drugs, free sex, violence, etc. The unharmonious relationship between parents

and children is also a cause of this condition. The strong oriental culture force our people to abstain from talking about sex and intercourse and families always try to find a way of avoiding a conversation about this.
To conquer the danger of HIV/AIDS, I think we can observe three points:

1. Family, as the basis of a community. Parents should guide their children from the beginning, talk openly to them and educate them about sex and intercourse.

2. Churches must be directly involved in this problem. It's not enough just to talk about spirituality, poverty and faith. What we need now is real action on the part of the churches. Churches should have a department that takes care of HIV/AIDS problems and provide pastoral counseling to the people. The pastors also need to be provided with many skills and knowledge about HIV/AIDS so that they can serve not only their congregation, but also the people w ho are infected with HIV/AIDS and need pastoral counseling. Churches, as the salt and light of the world, have to be of great influence to their surrounding.

3. The government should work together with the churches and non-governmental organizations in dealing with HIV/AIDS. They have to support each other. Government should build up foundations and provide funds to HIV/AIDS programs, make campaigns about the danger of HIV/AIDS and provide information to the society.

I hope that with this information and explanation, all of us will know about the situation in Indonesia and together we will plan for concrete ways how to take care of HIV/AIDS problems.

Participants of the workshop share their country reports

INDONESIA (Jane E.F. Sinaga, Batak Christian Community Church)

The epidemic in Indonesia started in 1986 when the first person died of AIDS in Bali. Now the total of cases up to September 1998 are 764 reported cases, 545 HIV+ and 219 AIDS cases. The most infected are young people, 47% are 20-29 years old, 28% are 30-39 years old and 5% are 15-19 year old, of which 71% are heterosexual, 13% homosexual-bisexual and 1% drug users.

In 1992, of the AIDS cases (people with AIDS or PWA) hospitalized in the General Hospital in Jakarta, there were 12 PWAs, of whom 8 were Christian young people. This was the time PALMA -- which is the only Christian non-governmental organization concerned with and caring for HIV/AIDS in Indonesia -- was born. PALMA means *Concern and Care for AIDS & Enhancement of Your Future* (Peduli AIDS & Lestarikan Masa Depan Anda).

PALMA is coordinating several activities for an by young people:

a. IEC (Information, Education and Communication) programs through churches in Indonesia are carried out with the special target groups being youth and ministers;

b. Training of motivators and counselors to prepare the church communities for prevention programs and information centers;

c. Peer group education as a module for training;

d. Topics not only HIV/AIDS, but also including NAZA (Narcotics & Alcohol), STDs and reproductive health and sexual education.

Campus student movements are carrying out several activities after being trained by private university coordinators. Hotline services, information centers and also the IEC programs using peer group education are carried out among students and lecturers.

Although 80% of the 200 million people of Indonesia are Muslim and only about 15% are Christian and Catholics, many cases of HIV/AIDS are found among Christian youth. Special attention and programs must be coordinated through churches with holistic approach and pastoral counseling.

MALAYSIA (Gabriel Yong, Basel Christian Church of Malaysia)

As a developing country, Malaysia is more exposed to HIV/AIDS than other developed nations. In Malaysia, up to the end of 21 January 1998, there were 24,236 Malaysians infected with HIV, while 1,160 AIDS deaths have been recorded since the first AIDS case was detected in December 1986. The figures show that at least 300 new HIV cases are detected every month throughout the country. However, this figure does not reflect the actual number because many cases are still to be reported or are not reported at all.

Most of the HIV carriers are people aged between 20 and 39 who form almost 90% of the total cases. The Health Ministry 1996 statistics showed that 72.83% of the 552 AIDS cases detected ruing that ten year period were those between the ages of 20 and 40.

In a developing country such as Malaysia, awareness and knowledge about HIV/AIDS is not widespread. The same is true of knowledge about preventive measures. Young people in the towns were more exposed to information on AIDS through peer interaction and the electronic and printed media, while their rural counterparts only received information in theory and from limited reading.

The main mode of transmission of the virus in Malaysia is by intravenous drugs addiction and abuse (drug injections with shared needles). The second mode was heterosexual relations followed by prostitution, homosexual/bisexual relations, blood transfusion and transmission from mother to baby.

Based on the analysis done by the Health Ministry, the main cause of HIV/AIDS is moral decadence and neglect of religion and its values.

For the past few years, the youth of the Basel Christian Church of Malaysia was actively involved in the Anti-drugs Addiction and Abuse Movement, an education and awareness-raising program jointly organized and supported by the local government.

The challenges which we are facing, is to reach out further towards *pastoral care, advocacy and alleviation of suffering for HIV/AIDS sufferers* where our efforts in these three aspects are still in need of improvement; act as an instrument of mass information among young people to provide information about the virus and its destructive capabilities, by means of Information technology (IT).

My vision is *Youth: Force for Change.* I plan to grow along with the pandemic. I wish that I could become involved in the programs to increase awareness, understanding, volunteerism and funding and to bring together a diverse spectrum of youth that care about AIDS.

THAILAND (Buathip Kitchawit, The Evangelical Lutheran Church in Thailand)

In Thailand the first HIV-infected cases were reported in 1984 among homosexuals and next spread rapidly among persons who injected themselves with drugs, male customers of sex workers and eventually from these men to their wives who can pass it on to their babies. Now there are about 1 million people who are infected with HIV in Thailand. Almost half of them are women (400,000-450,000) most of them in the reproductive age. About 2% of the pregnant women are found to be infected with the HIV virus which means about 20,000 women annually. So every year, due to transmission from mother to child, about 6,000 children also get infected with the HIV virus.

The Diakonia Department of the Lutheran Church in Thailand first started an AIDS project in 1992. However, the goal to give temporary shelter to HIV infected people was not reached in an appropriate way. Therefore, the project ended ad new plans were made. The new project emphasized a community based approach and home visiting. The project has two full-time workers and two part-time workers. The work is done in cooperation with the congregations and other Diakonia projects. During the last year congregations have been more ready to cooperate after facing this problem among their members. Once a year there has been a training course on different topics for the co-workers. Last year, the project regularly visited 15 families with one or more members infected with HIV. Counseling and spiritual and practical support was given during these visits. The project also offered financial help for medical expenses by cooperating with the government hospitals. Financial support was also given to unemployed HIV positive people for starting a small scale business.

The youth as a special group has not yet been reached by the project. It is surely the group which has to face this problem. All the time more and more people are getting visible symptoms and are more openly recognized as AIDS patients. The youth are an important resource for the church. There is still a lack of open discussion about sex and sexuality, morality and ethics in the families and in the congregations. For teenagers first sex is usually with friends and is unprotected. According to some statistics the medium age for Thais to have their first intercourse is decreasing. Visiting brothels and having minor wives is still common for Thai men. Having sexual experiences has been seen as particularly important for men.

Our Diakonia Department has a home for unmarried pregnant mothers who have no place to go. Many of these mothers are very young. We have regularly arranged group discussions and education for this group. Providing this group with the appropriate knowledge is a challenge for us.

Concerning the future our main wishes are involved in getting volunteers to work with us, visiting HIV infected people as friends. Our vision is to encourage our congregations and other Diakonia projects to be loving caring and supporting communities for those who are infected with HIV.

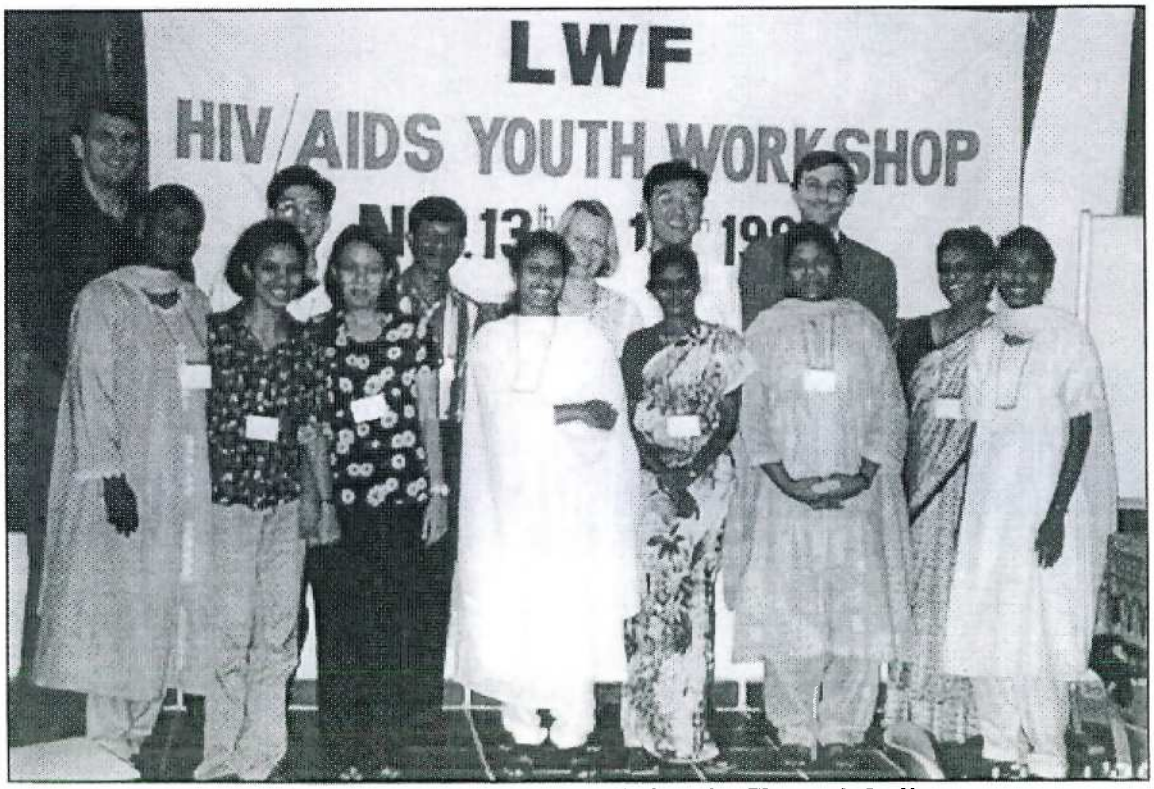
Nowadays many HIV infected people have heavy a financial burden to carry. The economic situation in Thailand has made it even worse. Therefore, in the future we wish to be able to offer

some kind of work which is possible to do either at home or at our office premises. One of our visions is also a kind of Christian cell group where those infected with HIV could sh are their experiences and encourage each other.

Daily Bible studies during the workshop were lead by local resource persons

APPENDICES :

1. **TIME TABLE**
2. **LIST OF PARTICIPANTS**
3. **HIV/AIDS FACT SHEET**



Participants of the AIDS Workshop in Chennai, India

TIMETABLE - AIDS WORKSHOP IN CHENNAI, INDIA, NOVEMBER 13-17, 1996

Time	Thursday November 12	Friday November 13	Saturday November 14	Sunday November 15	Monday November 16	Tuesday November 17
7:00-8:00		------ BREAKFAST ------				
8:00-9:00		**DEVOTION - BIBLE STUDY** *(John Rajkumar)*			**DEVOTION - BIBLE STUDY** *(John Rajkumar)*	
9:00-10:00		Opening Introduction to the program *(Ondrej Prostrednik)*	Case Studies on HIV/AIDS Prevention Programs *(S. Krishnamurthy)*	**Worship with the local church** (CSI Church, Adyar) **Visit to Gurukul Clinic**	Creating Publications *(S. Meshack)*	Summing up
10:00-10:30		TEA BREAK			TEA BREAK	
10:30-12:30		HIV/AIDS Facts, Figures, Analysis (*Sheila Shyamprasad*)	Christianity, Culture and AIDS *(Sheila Shyamprasad)*		Home Care for AIDS patients and their families *(S. Solomon)*	Closing of the workshop
12:30-14:00		------ LUNCH ------				
14:00-15:00		Developing Curricula for HIV/AIDS Education *(Rob Lane)*	Case Studies of people living with AIDS *(A.J. Hariharan)*	Visit to YRG Center	Games for Youth in HIV/AIDS *(Vinita Chitale)*	Departures
15:00-16:00		HIV/AIDS and Human Rights (*Rob Lane*)	cont.	*Cont.*	Drama - A tool to change behavior *(Vinita Chitale)*	
16:00-16:30		------ TEA BREAK ------				
16:30-18:00		Discussion	Discussion	Visit to Tambaram	Discussion	Departures
18:00-20:00	Introduction of the participants	Country reports	CULTURAL PROGRAM			
20:00-21:00	------ DINNER ------					

ARRIVALS

APPENDIX 1

APPENDIX 2

LIST OF PARTICIPANTS

AIDS WORKSHOP IN CHENNAI
November 13-17, 1998

PARTICIPANTS:

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APPENDIX 3

HIV/AIDS FACT SHEET

✓ *Human Immuno-Deficiency Virus* (HIV), is a retro virus that attacks the human immune system. It is a retro virus, which means its reproduction depends on using genetic material of cells it invades to produce more virus; it eventually destroys those cells.

✓ Symptoms almost never appear immediately after HIV infection is transmitted. Some individuals go ten or more years without any indications of disease, though the virus is in the body, and they are capable of infecting others. The infection can be detected by a simple laboratory test. Current research indicates the importance of early testing for anyone who might have been exposed to the virus so that appropriate care and planning can begin early

✓ *Acquired Immuno-Deficiency Syndrome* (AIDS), is the term describing the later stages of HIV infections, when the levels of important immune system cells have dropped, and the individual has started to develop opportunistic infections or cancers. Even at this stage, an individual may not look obviously ill, though experiencing many problems. Many individuals are not diagnosed until this late stage, making supportive treatment difficult. Drugs to limit the virus, to stimulate the immune system, and to prevent opportunistic infections are often being prescribed at this point.

✓ More than fifteen years after AIDS was identified, it is still without cure some say a cure will eventually come within the next 20 years. At the same time, HIV infected persons are living longer as treatments improve.

✓ Symptoms do not always appear early following infection. Some persons are more resistant to disease, depending on the condition of their overall health, stress levels, nutritional base, and other factors. Symptoms may not appear for ten or more years.

✓ Many of the symptoms are similar to those of the common cold, the flu, and other illnesses. The difference is the severity and the length of time that the symptoms last.

✓ Following infection and the breakdown of the immune system, some of the following symptoms may be experienced:

- ♦ unexplained, persistent fatigue
- ♦ unexplained fever, night sweats or shaking chills that last for several weeks or more
- ♦ sudden and unexplained weight loss of more than 10 pounds
- ♦ diarrhea that continues for several weeks
- ♦ a dry cough that will not go away, often associated wit shortness of breath
- ♦ purple or pink spots or bumps on or under the skin, inside the mouth, nose, or around the eyes; these spots are generally harder than t he skin around them and persist for more than six weeks
- ♦ white spots around or in the mouth that last for weeks
- ♦ swollen glands (in neck, groin, armpits) that last for several months
- ♦ repeated vaginal infections